U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-346/92016(DRS)

Docket No. 50-346 License No. NPF-3

Licensee: Centerior Service Company
c/o Toledo Edison Company
300 Madison Avenue
Toledo, OH 43652

Facility Name: Davis-Besse Nuclear Power Station

Inspection At: Oak Harbor, OH 43449

Inspection Conducted: January 29-30, May 29, July 12 and 29, November 18-19, 1991, and October 6, 1992

Inspectors: Timothy D Reidinger 11-3-92
Timothy D. Reidinger Date

Frank J Jablonski for 11-3-92
Joseph M. Ulie Date

Approved By: Frank J Jablonski 11-3-92
Frank J. Jablonski, Chief Date
Maintenance and Outages Section

Inspection Summary

Inspection on January 29-30, May 29, July 12 and 29, November 18-19, 1991, and October 6, 1992 (Report No. 50-346/92016(DRS))
Areas Inspected: Special, announced inspection of licensee action on a previous inspection finding regarding the implementation of Abnormal Procedure DB-OP-02519, Serious Control Room Fire, Revision 1, dated May 18, 1990. The inspection was performed in accordance with NRC Inspection Procedures 30703 and 92701.
Results: Within the area inspected, one deviation was identified: procedural inadequacy of initiating a station blackout contrary to a commitment in Davis-Besse letter Serial No. 1718 as described in Paragraph 2. An apparent weakness was identified in validating complex procedures as described in Paragraph 3. A synopsis of OI Report No. 3-90-016 is included as an enclosure to this report.

DETAILS

1. Persons Contacted

Toledo Edison Company

R. Brandt, Manager, Plant Operations (Acting) (formerly)
*C. Hengge, Fire Protection, Coordination Supervisor
M. Murtha, Fire Protection Engineer
*R. Schrauder, Manager, Nuclear Licensing
V. Sodd, Operations Shift Supervisor
K. Spencer, Licensing
D. Staudt, Operations Shift Supervisor
*M. Turkal, Licensing
L. Young, Fire Protection (formerly)

Sonalysts, Incorporated

K. Parkinson, NRC Consultant

U. S. Department of Energy

D. Kubicki, Fire Protection Engineer (former NRC Reviewer)

U. S. Nuclear Regulatory Commission

*F. Jablonski, Chief, Maintenance and Outages Section

The inspectors also contacted other licensee employees during the course of the inspection.

*Denotes those personnel participating in the telecon exit meeting held on October 6, 1992.

2. Action or Previous Inspection Findings

(Closed) Unresolved Item (346/90007-01(DRS)): During the May 21-24, 1990 inspection, the NRC discovered that a station blackout could have occurred when implementing Abnormal Procedure DB-OP-02519, "Serious Control Room Fire," Revision 1, dated May 18, 1990 (post fire safe shutdown procedure). Yet, in the Davis-Besse letter to the NRC, Serial No. 1713, dated October 11, 1989, the licensee committed to not induce a station blackout when implementing the post fire safe shutdown procedures.

Supplementary actions described in paragraph 4.1.1.a.7 of Procedure DB-OP-02519 stated, "Trip all A and B bus source breakers," in the event of a serious control room fire, which caused a loss of offsite power conditions. The actions described in paragraph 1.0.b.4.a of the procedure,

Attachment 2, specified that when component cooling water (CCW) flow is not indicated and emergency diesel generator (EDG) No. 1 is running, then depress the emergency shutdown pushbutton on panel C3621, EDG No. 1 engine control panel. Also, when there is no indication of CCW flow, paragraph 1.0.c of the procedure directed that the emergency shutdown button be depressed on panel C3622, the EDG No. 2 engine control panel. The note in paragraph 1.0.c stated, "This step shall be performed even if EDG 1 is not running." Concurrent with the steps above, Attachment 4 to Procedure DB-OP-02519 requires operators verify CCW flow and to start CCW pumps, if necessary.

NRC inspectors determined however, that Procedure DB-OP-02519 would have caused shutdown of EDG No. 1 before an operator could have completed steps to ensure that CCW flow was being provided (verify component cooling water (CCW) pumps 1 or 3). NOTE: EDG No. 2 was unprotected from fire and therefore, assumed inoperable. Manual action to close either of the CCW pump breakers may have been required if a fire induced spurious loss of CCW had occurred.

By performing the above actions concurrently as written in the procedure, a station blackout would have occurred. This is contrary to the message sent to the NRC in Davis-Besse letter Serial No. 1718. The procedural inadequacy of initiating a station blackout is considered a deviation from the specified commitment (346/92016-01(DRS)).

On May 24, 1990, during the inspection, the licensee committed to revise Abnormal Procedure DB-OP-02519 prior to startup. The procedure as revised will not initiate a station blackout.

3. Apparent Weakness In Validating Complex Procedures

The inspectors determined that there was an apparent weakness in the manner which complex time dependent procedures were validated between operations and engineering departments. For example, the validation process described by the operations staff for Abnormal Procedure DB-OP-02519 indicated that the individual procedure attachments were walked through individually in successive order rather than in a timed concurrent order. Based on the previous discussions it appeared to the inspectors that the validation process for this procedure should have been concurrently timed and integrated to ensure unplanned plant transients would not occur.

4. Synopsis of Previous Investigation

Aspects of the May 21-24, 1990 inspection, were referred to the NRC Office of Investigations. A synopsis of the ensuing investigation is provided in the enclosure to this report.

5. Deviation

A licensee's failure to satisfy a written commitment or to conform to the provisions of applicable codes, standards, guides, or accepted industry practices when the commitment, code, standard, guide, or practice involved has not been made a legally binding requirement by the Commission, but is expected to be implemented. A deviation from a written licensee commitment is discussed in Paragraph 2.

6. Exit Interview

The inspector held a telecon exit interview with licensee representatives (denoted in Paragraph 1) at the conclusion of the inspection on October 6, 1992, and summarized the scope and findings of the inspection. On October 16, 1992, the inspector discussed the likely informational content of the inspection report with regard to documents reviewed by the inspectors during the inspection. The licensee did not identify any of the documents as proprietary.

SYNOPSIS OF OI REPORT NO. 3-90-016

On September 27, 1990, the Regional Administrator, U. S. Nuclear Regulatory Commission (NRC), Region III (RIII), requested that an investigation be initiated concerning an allegation that the Operations Supervisor, Davis-Besse Nuclear Power Station (DBNS), Toledo Edison Company, deliberately misled an NRC contract inspector concerning the timeline of Abnormal Procedure No. DB-OP-02519 Revision 1, "Serious Control Room Fire." Also, the investigation was to focus on management's culpability, if any, based on the licensee's October 11, 1989, letter to the NRC which stated that their procedure would not cause a station blackout when, in fact, a subsequent inspection showed that the procedure, if followed as written, would have caused a station induced blackout.

The Office of Investigations (OI), RIII, investigation did not substantiate the allegation that the Operations Supervisor deliberately misled the NRC Inspector. The investigation also did not substantiate the allegation that DBNS management intentionally misled the NRC in their letter dated October 11, 1989, regarding station blackout. During the investigation, however, an allegation surfaced that the Operations Supervisor made material false statements to OI:RIII investigators. There was insufficient evidence developed during the OI investigation to conclude that the Operations Supervisor deliberately made material false statements to investigators of OI:RIII.